STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125023	A. BUILDING: _____ B. WING _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANAI COMMUNITY HOSPITAL	628 7TH STREET LANAI CITY, HI 96763

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4 000	Initial Comments A licensure survey was conducted by the Office of Health Care Assurance from 09/23/19 through 09/26/19. The facility was found not to be in substantial compliance with Title 11, Chapter 94.1, Nursing Facilities. The census was 9 residents.	4 000		
4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth. This Statute is not met as evidenced by: Based on record review and interview with facility staff, the facility failed to ensure 1 (Resident 4) of 5 residents reviewed for unnecessary medication was monitored for the use of an anticoagulant to maintain a residents highest practicable health status. Findings include: Resident (R)4 was admitted to the facility on 01/19/18. R4's diagnoses include the following:	4 136	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The Electronic Medical Record (EMR) for R4 was immediately reviewed for the most recent PT/INR lab value result. The most recent PT/INR level drawn for September was within defined limits. A PT/INR level	11/10/19

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4 136	Continued From page 1 dysphagia, late effect of stroke; hemiplegia and hemiparesis, right non-dominant side, late effect of stroke; hypoglycemia; and communication disorder. A record review on 09/24/19 at 10:30 AM found physician's orders for September 2019 which include aspirin, 81 mg chewable tablet, one tab daily (diagnosis: blood thinner) and warfarin sodium, 1 mg, 1.5 tabs every afternoon at 1700 (diagnosis: afib/flutter). Further review found the following lab orders: 01/22/18 for PT/INR monthly, first Monday and 10/02/18 INR goal range 2 to 3, call critical results. A review of the lab reports found missing lab result for PT/INR for the months of March, June and July 2019. On 09/24/19 at 12:07 PM a concurrent review of the Electronic Health Record (EHR) and interview was conducted with the Director of Nursing (DON). The DON found the results for March and July 2019; however, could not locate the lab results for June 2019. The DON was agreeable to follow up. A review of the pharmacy medication regimen review found reviews were done on 06/07/19, 07/08/19, 08/05/19 and 09/09/19. The review for August referenced an INR result of 2.8 from 05/06/19. However, there is no further documentation of subsequent lab results that were reviewed by the pharmacist. On 09/24/19 at 12:48 PM, the DON confirmed that the PT/INR was not done for the month of June 2019. The DON reported a chart audit done in July 2019 also confirms the lab for the resident's PT/INR was not done in June.	4 136	was re-drawn on 9/26/2019. Results for 9/26/2019 were also within defined limits. R4 was assessed by the charge nurse. R4 did not have any signs and symptoms of coagulopathy or hypercoagulability. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: An audit for all residents will be conducted by the Director of Nursing (DON) to identify any orders for regular lab draws. The audit will also include a review of each resident□s Medication Administration Record (MAR) to identify any resident who takes medication that requires lab monitoring. Any orders for regularly scheduled labs will be placed on the Nursing Calendar located at the Charge Nurse station and will be notated on the front page of the MAR binder. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Nursing (DON) will provide verbal and written didactic education to the licensed nursing staff. Education will be completed by 11/10/2019. Topics	

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4 136	Continued From page 2	4 136	include a) Lab Notification Protocol and b) therapeutic ranges and critical values for PT/INR. A new process for Routine Lab Orders will be implemented by 11/10/2019. The DON will provide a written copy of the protocol, as well as verbal overview of the process with demonstration to the nursing staff and physician. The Routine Lab Order process is as follows: 1. Any Routine Lab that is ordered (one that occurs at a regular frequency such as monthly, weekly, every 1st Monday, etc.) will be placed on the monthly desk calendar located at the charge nurse station. 2. The charge nurse will review the desk calendar daily and order any labs scheduled for the day. The charge nurse will call the lab and confirm that the order was received. 3. The charge nurse will review the desk calendar daily and follow up on any labs that were drawn the previous day to ensure that a) order was received by lab and b) results were received by the nursing staff. 4. Upon receipt of the lab results, the charge nurse will print out the results and place in the resident□s paper chart for review by the physician and the pharmacist. The results will be flagged for acknowledgement signature from the physician. 5. Once a week, the charge nurse will review the desk calendar and ensure that all labs for the previous week were ordered, resulted, and reported to	

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4 136	Continued From page 3	4 136	physician as necessary. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Charge Nurse will conduct a monthly audit of all Routine Lab Orders to ensure that there are no missed Routine Lab Orders. Results of this audit will be reported at the monthly Quality Assurance/Performance Improvement meeting that is monitored by the Director of Nursing. Additionally, the Charge Nurse will track the monthly PT/INR for any resident who is taking coumadin. At the monthly QAPI meeting monitored by the Facility Administrator, the Director of Nursing will report the PT/INR for any resident taking coumadin.	
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy. This Statute is not met as evidenced by: Based on observation, interview with staff member, and review of the facility's policy and procedures, the facility failed to ensure opened	4 197	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	11/10/19

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4 197	Continued From page 4 drugs were labeled. Findings include: On 09/25/19 at 08:45 AM concurrent observation of the medication cart was done with Charge Nurse (CN)1. The polyethylene glycol (MiraLax) powder for Resident (R)9 found the bottle was not labeled with an open date. CN1 reported the powder should be labeled to ensure it is discarded after 30 days. Further observation found a bottle of chlorhexidine gluconate for R1 which was not labeled with an open date. CN1 confirmed there was no label with an open date. CN1 stated that the chlorhexidine gluconate will be thrown out. On 09/25/19 at 09:00 AM concurrent observation and interview was done with the Director of Nursing (DON). Approximately 15 minutes later, the MiraLax powder was still on the medication cart, the DON confirmed the bottle was not labeled. The DON stated liquids require labeling with open dates. The DON was agreeable to provide a copy of the facility policy and procedures regarding medication storage and labeling. On 09/25/19 at 09:01 AM, the DON provided the policy and procedure entitled "Storage of Medications and Solutions in Patient Care Areas". Noted under procedure, "place open and discard dates on solution bottles".	4 197	AFFECTED BY THE DEFICIENT PRACTICE: The MiraLax powder and chlorhexidine gluconate were discarded. New bottles were opened and immediately labeled with dates prior to administration to residents. The Director of Nursing (DON) provided a written copy of the Policy and Procedure Storage of Medications and Solutions in Patient Care Areas to CN1. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: On each shift, the Charge Nurse will inspect all medication carts and refrigerators to identify any medication/biological that is open and does not have a label indicating the label date. If any are found, they will be immediately discarded. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Nursing (DON) will provide verbal and written didactic and return demonstration education to	

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4 197	Continued From page 5	4 197	licensed nursing staff. Education will be completed by 11/10/2019. Topics include a) medication labelling practices b), expiration guidelines, and c) expectations for daily medication cart/fridge checks. The new process to be implemented before 11/10/2019 is as follows: 1. Once a shift, a licensed nurse will check all open medications (in all medication carts and all medication refrigerators) to ensure that they are labeled with an open date and an expiration date. 2. Once a day, a licensed nurse will properly dispose of any medication that is expired according to the label open date notated. 3. Once a day, a licensed nurse will properly dispose of any medication that is open without a label indicating date of open and/or date of expiration. 4. A licensed nurse will record the findings of these daily checks onto an audit tracking form. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Nursing (DON) will conduct a monthly audit of the Daily Tracking Form that is completed by the licensed nurses daily. The results of this audit will be reported to the monthly Quality Assurance/Performance Improvement meeting that is monitored by the Facility Administrator.	

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4 197	Continued From page 6	4 197	Once a month, the DON will conduct walking rounds to inspect all medication carts and medication refrigerators to monitor for compliance. The DON will present the findings from the monthly walking rounds to the month Quality Assurance/Performance Improvement meeting that is monitored by the Facility Administrator.	